at the end of the visit. At the check-out window after the visit, each patient received a paper copy of the complete encounter note. In addition, patient survey results showed high satisfaction with this process (mean, 97%). Patients appreciated being given the chance to coauthor their medical record and felt better heard and understood.

Federal laws give patients the right to access and amend their medical record.6 A cultural change is needed to make it commonplace for patients to access and amend their EHRs.

I foresee EHR documentation improving with the mindset of communication scholars. As patients become more involved in framing their stories and crafting their narratives, communication models such as Knapp’s will guide us. For now, however, the US medical system is stuck. The transition from paper medical records to EHRs has eroded communication and displaced providers into overwhelming tasks of stenography and basic data entry. Our current trajectory is not sustainable as medical documentation needs to be accurate and truthful. Our prehistory research shows a process that remedies the integrity of EHR data, improves workflow, and fosters the patient-provider relationship. (doi:10.7556/jaoa.2018.078)

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Disclaimer: Dr. Warner is president of Patient Advocacy Initiatives, a 501(c)(3) nonprofit organization that offers free paper and digital prehistory forms as well as free educational material to empower individuals to be their own patient advocate.

References

**Tool for Predicting Medical Student Burnout From Sustained Stress Levels**

To the Editor:

We read with great interest the article by Johnson et al1 in the March 2018 issue of _The Journal of the American Osteopathic Association_. The authors performed an observational study to examine the factors of the Medical Education Hassles Scale-R to identify subscales that would be useful to categorize hassles for research and assessment purposes. They identified 7 subscales: (1) Academic and Time Pressures, (2) Financial, (3) Social, (4) External Influences, (5) Day-to-Day Functioning, (6) Relationships With Immediate Family, and (7) Health. The authors should be congratulated for performing a well-designed study on an important topic (ie, well-being) in graduate medical education and physician practice.2,3 The need to identify specific areas for intervention is an innovative concept that has not been appropriately explored.4,5

Although the study1 was well conducted, some elements of the study need to be clarified by the authors. First, the assessment instrument used 101 individual questions, which represents a long length of participation that can induce response fatigue in participants. Current instruments evaluating burnout have been validated using only 2 questions.6 Second, the authors did not examine the degree to which program leadership contributes to burnout. It is possible that program leadership wellness and support can be protective to student burnout. Third, other factors leading to trainees’ burnout (eg, working hours, control over professional life) may also have affected the study results and need to be further explored.

We would welcome some comments from Johnson et al1 to address these issues and thus further substantiate the findings of this important study. (doi:10.7556/jaoa.2018.079)

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References
Response

I appreciate the opportunity to discuss our study examining the factor structure of the Medical Education Hassles Scale-R (MEHS-R) presented by Kendall and Castro-Alves. Kendall and Castro-Alves identified 3 questions for which they requested clarification and additional information: (1) potential survey response fatigue caused by the length of the MEHS-R, (2) the effect of program leadership on burnout, and (3) other factors that may lead to burnout in medical students.

Regarding the first question, survey response fatigue can occur from the number of items on a survey or from the number of surveys given within a short period. Wolf et al included the item “filling out forms” as 1 of the 101 items on the MEHS-R. In recognition of the potential for survey response fatigue, we examined the frequency of endorsement as a hassle and variability of responses to the 101 items of the MEHS-R (unpublished data). Almost 50 items had responses with infrequent endorsement as a hassle and low variability of responses, indicating they could potentially be eliminated from the scale. Factor analysis of the modified 53-item MEHS-R identified 5 subscales with adequate Cronbach α, and the fit indices for the confirmatory factor analyses conducted were marginally higher than those of the 101-item MEHS-R analysis. However, the elimination of some items may have resulted from the rural location of the medical schools included in the study. Additional testing at a larger variety of medical schools would improve the validity of the process. Even with the elimination of almost 50 items to form the modified MEHS-R, information on many different potential hassles is necessary to identify the types of stress that predict burnout to develop effectively targeted wellness interventions. As such, the need to obtain more specific information about the stress experienced by medical students may outweigh the risk of potential survey response fatigue.

The other 2 questions of Kendall and Castro-Alves both relate to factors that potentially affect medical student burnout apart from the types of stress identified by our study. Learning environment, including support from program leadership and clerkship organization, and some medical student workplace factors such as overnight call are significant predictors of burnout in medical students, while other factors, such as number of patients seen, are not. Future studies could examine whether the types of stress experienced by medical students moderate the relationship of learning environment and workplace factors with burnout. Results of such studies could further aid in the development of targeted wellness interventions to reduce or prevent burnout in medical students.

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References


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